

Becket Systems

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NOTICE OF INDEPENDENT REVIEW DECISION

DATE OF REVIEW: Mar/11/2010

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE: Outpatient left shoulder arthroscopic subacromial decompression and debridement with an open rotator cuff repair

DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION:

M.D., Board Certified Orthopedic Surgeon

REVIEW OUTCOME:

Upon independent review, the reviewer finds that the previous adverse determination/adverse determinations should be:

☒ Upheld (Agree)

☐ Overturned (Disagree)

☐ Partially Overturned (Agree in part/Disagree in part)

INFORMATION PROVIDED TO THE IRO FOR REVIEW

MRI Lt. Shoulder, 12/15/08

Office note, Dr. 06/16/09

Office notes, Dr., 06/24/09, 09/15/09, 09/30/09, 10/22/09

EMG/NCV studies, 07/13/09

Consult, Dr. 01/11/10

Letters from 01/26/10, 02/04/10

Official Disability Guidelines Treatment in Worker's Comp, 14th edition, 2010 updates:

Shoulder -- Surgery for impingement syndrome

ODG Indications for Surgery – Acromioplasty

Notice of Utilization Review Findings, 1/26/10, 2/4/10

PATIENT CLINICAL HISTORY SUMMARY

This right hand dominant female sustained multiple injuries on xx/xx/xx when she was assaulted while trying to restrain a prisoner. A diagnosis of left wrist sprain and left shoulder sprain were documented following evaluation, x-rays and treatment in the emergency room. The claimant underwent a subsequent left carpal tunnel release with tenosynovectomy. The 12/15/09 left shoulder MRI revealed evidence of mild tendinosis/tendinitis involving the periphery of the supraspinatus tendon with minimal compromise/impingement of the subacromial space. The claimant reported continued left shoulder pain, stiffness, and difficulty with overhead activities as well as sleeping due to pain. Left shoulder x-rays revealed no abnormalities, fractures or subluxations. The 01/11/10 exam showed severe tenderness in the anterolateral aspect with decreased and painful range of motion and a positive impingement sign along with weakness and decreased sensation. A diagnosis of left

shoulder impingement syndrome was documented which had failed to improve with conservative measures including medications, activity modifications, physical therapy and cortisone injections.

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDING CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION

The claimant is a female who injured her left shoulder on xx/xx/xx. An MRI was obtained in December of 2008, which demonstrated very mild tendinitis involving the supraspinatus tendon, no evidence of a rotator cuff tear. The claimant was evaluated by Dr. in January 2010 who noted that the claimant has undergone therapy, got no relief whatsoever from a cortisone injection, has decreased range of motion and impingement sign present. If one looks towards the ODG guidelines for acromioplasty, conservative care is recommended for at least six months, which the patient has undergone. There should be subjective clinical findings of pain with active arc motion 90 to 130 degrees, which is not documented on exam. There should be objective clinical findings of absent abduction, which is present, a positive impingement sign, which is present, and temporary relief of pain with a diagnostic injection, which was not performed. Plus, there should be an MRI showing positive evidence of impingement. The MRI does show some supraspinatus tendinosis. ODG Guidelines for rotator cuff repair include a proven rotator cuff tear. Records indicate the patient had not had relief of pain with an anesthetic injection and shows no pain with active arc motion from 90 to 130 degrees. Based on the medical records provided and the ODG, the reviewer finds that medical necessity does not exist for Outpatient left shoulder arthroscopic subacromial decompression and debridement with an open rotator cuff repair.

Official Disability Guidelines Treatment in Worker's Comp, 14th edition, 2010 updates:
Shoulder -- Surgery for impingement syndrome

ODG Indications for Surgery| -- Acromioplasty

Criteria for anterior acromioplasty with diagnosis of acromial impingement syndrome (80% of these patients will get better without surgery).

1. Conservative Care: Recommend 3 to 6 months: Three months is adequate if treatment has been continuous, six months if treatment has been intermittent. Treatment must be directed toward gaining full ROM, which requires both stretching and strengthening to balance the musculature. PLUS
2. Subjective Clinical Findings: Pain with active arc motion 90 to 130 degrees. AND Pain at night. PLUS
3. Objective Clinical Findings: Weak or absent abduction; may also demonstrate atrophy. AND Tenderness over rotator cuff or anterior acromial area. AND Positive impingement sign and temporary relief of pain with anesthetic injection (diagnostic injection test). PLUS
4. Imaging Clinical Findings: Conventional x-rays, AP, and true lateral or axillary view. AND Gadolinium MRI, ultrasound, or arthrogram shows positive evidence of impingement.

A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION

☐ ACOEM-AMERICA COLLEGE OF OCCUPATIONAL & ENVIRONMENTAL MEDICINE UM KNOWLEDGEBASE

☐ AHCPR-AGENCY FOR HEALTHCARE RESEARCH & QUALITY GUIDELINES

☐ DWC-DIVISION OF WORKERS COMPENSATION POLICIES OR GUIDELINES

☐ EUROPEAN GUIDELINES FOR MANAGEMENT OF CHRONIC LOW BACK PAIN

☐ INTERQUAL CRITERIA

☒ MEDICAL JUDGEMENT, CLINICAL EXPERIENCE AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS

☐ MERCY CENTER CONSENSUS CONFERENCE GUIDELINES

☐ MILLIMAN CARE GUIDELINES

☒ ODG-OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES

☐ PRESSLEY REED, THE MEDICAL DISABILITY ADVISOR

☐ TEXAS GUIDELINES FOR CHIROPRACTIC QUALITY ASSURANCE & PRACTICE PARAMETERS

☐ TEXAS TACADA GUIDELINES

☐ TMF SCREENING CRITERIA MANUAL

☐ PEER REVIEWED NATIONALLY ACCEPTED MEDICAL LITERATURE (PROVIDE A DESCRIPTION)

☐ OTHER EVIDENCE BASED, SCIENTIFICALLY VALID, OUTCOME FOCUSED GUIDELINES (PROVIDE A DESCRIPTION)